SEICTF Mileage Reimbursement

Employee: _____ Claim Number: _____ Date of Injury: _____

Please complete each section of this form for each day mileage reimbursement is being claimed.

Date(s)	Name and address of Physician or Medical Facility	Beginning Address	Address of Final Destination after Appointment	Round Trip Miles
Date:	**Physician:**	**Street:**	**Street:**	**Miles:**
	Street:	**City, State:**	**City, State:**	
	City, State:			

I wish to be reimbursed for the above mileage. I understand the reporting of false information may disqualify me from receiving SEICTF benefits and certify the above information is correct to the best of my knowledge.

Mail to: Finance, Risk Management
P.O.Box 1390
Montgomery, AL 36102

Claimant's Signature: _____

Date: _____

REV 10/08